DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011
(202) 576-6265

Date of This Report

Employee Social Security Number

Employer Identification Number

Insurer Number

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYER/INSURER

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. ONE COPY SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS COMPENSATION AT THE ABOVE ADDRESS, ONE COPY SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND ONE COPY SHOULD BE RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7A DCWC, WHICH CAN BE OBTAINED FROM YOUR EMPLOYER, FROM THE OFFICE OF WORKERS COMPENSATION, OR FROM THE DEPARTMENT OF EMPLOYMENT SERVICES WEB SITE.

Date and Time of Injury
am/pm?

Place where injury occurred:

Description of Injury:

THIS IS TO NOTIFY YOU

Employer

THAT I _____, while in your employ,

sustained an injury 9 **or contracted an occupational disease** 9 **as described above, caused by:**

Treating Physicians Name and Address

(Employee's Signature)